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October 17, 2007

Eric A. Cioppa, Acting Superintendent
c/o Vanessa Leon
Docket No. INS-07-1000
Maine Bureau of Insurance
34 State House Station
Gardiner, Maine 04333-0034

RE: ANTHEM BCBS 2008 HEALTHCHOICE INDIVIDUAL RATE FILING

I. FILING COVERSHEET

Dear Superintendent Cioppa:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach

DATE: October 17, 2007

DOCUMENT TITLE: Prefiled Testimony of William Whitmore

DOCUMENT TYPE: Prefiled Testimony

CONFIDENTIAL: **No**

Thank you for your assistance in this matter.

Very truly yours,

/s/ *Christopher T. Roach*

cc: Thomas C. Sturtevant, Esquire
Christina M. Moylan, Esquire
Judith M. Shaw, Deputy Superintendent
James Bowie, Esquire

NON-CONFIDENTIAL

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE:	)	EXHIBIT 3
	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2008 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC	)	PREFILED TESTIMONY OF WILLIAM WHITMORE
	)	
DOCKET NO. INS-07-1000	)	
	)	October 17, 2007

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Q. Please state your name and your position with Anthem Blue Cross and Blue Shield ("Anthem BCBS").

A. My name is William M. Whitmore. I am the Director of Local Group Pricing for Anthem BCBS in Maine and New Hampshire and situated in its Maine office.

Q. Please describe any relevant education or experience that qualifies you as a witness today.

A. I am an Associate of the Society of Actuaries and a member of the American Academy of Actuaries. I have been a member of the Actuarial Department of Anthem BCBS, and its predecessor Blue Cross Blue Shield of Maine, since 1989, with the exception of fourteen months in 2001 and 2002. During my career with Anthem BCBS I have had numerous responsibilities including individual pricing, group pricing, trending, reserving, new product development and pricing, analysis of provider contracting, development of capitation models, legislative review and analysis, Dirigo Health review and pricing, medical policy review, behavioral health pricing, and dental pricing. Currently I am responsible for small and large group pricing in Maine and New Hampshire and individual (under age 65) pricing in Maine. I was responsible for the production of the most recent HealthChoice individual rate filings for Anthem BCBS in the fall of 2002, 2004, 2005, and 2006.

During the fourteen months in 2001 and 2002 when I was away from Anthem BCBS I worked for Milliman USA, an actuarial consulting firm, in its Portland, Maine office. During this time I worked on pricing and reserving for long and short term disability insurance plans as well as project work for Anthem BCBS on a consulting basis.

I am a lifelong resident of the State of Maine and a graduate of Bowdoin College in Brunswick, Maine where I earned a Bachelor of Arts degree with a major in mathematics.

Q. Please state your reasons for testifying at this hearing.

A. I am testifying at this hearing to respond to any questions about proposed 2008 premium rates for Anthem BCBS's HealthChoice products.

Q. What is the primary reason that Anthem BCBS has filed for the proposed premium changes.

A. As in recent years the claim costs associated with HealthChoice continue to increase and the current level of premium will not be sufficient to cover the cost of claims along with the cost of administering the services associated with the health insurance product. Claim costs continue to increase in all types of services and settings including hospital, physician, and pharmacy. Claim costs are increasing not only due to medical inflation in the cost of services but due to an increasing use of those services every year. These cost increases are exacerbated by the current regulatory requirements that mandate guarantee issue and guarantee renewal. These requirements result in a small number of HealthChoice subscribers consistently driving the level of claim costs higher. With no ability to rate those subscribers according to their risk and claim experience, the required premiums must rise to cover those costs. Anthem BCBS is well aware of the limited health insurance options available to individual subscribers, that are due in large part to other carriers' unwillingness to enter this risky market.

Q. Briefly summarize the proposed premium changes.

A. The average premium increases across all twenty three benefit options within HealthChoice is 13.3% with a range of 0.7% to 17.5%. For the Non-Mandated options the range of increases is 1.1% to 17.5% with an average of

13.6%. For the Mandated options the range of increases is 0.7% to 6.0% with an average of 6.1%. As explained in more detail to follow, these increases are lower than those included with the original filing.

Q. Why are the rate increases described above lower than those originally proposed?

A. There are two categories of changes that contribute to the decrease in the proposed rates: (1) analysis of recent claims data; and (2) modifications made during the discovery process. With respect to claims data, due to the timelines associated with this filing and hearing it is necessary to develop the filing and proposed rates approximately six months in advance of the proposed effective date. We therefore need to use claim data approximately eight months prior to the proposed effective date in order for that data to be mature enough to be a sound basis for the development of premiums. Prior to the hearing date Anthem BCBS analyzes new data in order to recognize any changes which may impact the level of rates required to cover claims and other costs. Additionally, during the discovery process and questioning Anthem BCBS has reviewed other assumptions in the filing and made minor changes which will be described herein.

Q. Before hearing about the changes made to the original filing, can you describe what you meant by "data to be mature enough" in your response to the previous question?

A. Yes. Claim data used as the basis from which to project future claim costs is not totally "mature", or "runout". What this means is that for the base period (in the original filing the base claim period was twelve months of incurred claims covering the time from May 1, 2006 through April 30, 2007) not all claims that were incurred have been paid. Therefore, it is necessary to estimate the amount of claims that have not yet been paid. The older the period, the fewer claims that have not been paid, and thus the more accurate the estimate of the claims actually incurred for that time. Anthem BCBS typically uses a minimum of two months beyond an incurred period to create less variance in claim estimates.

Q. Back to the original question: why are rate increases lower than those proposed in the original filing?

A. The primary reason is due to a review of more recent claim data as described above. As of last week Anthem BCBS now has claim data which has been paid through the month of September, 2007. Anthem BCBS not only updated the original claim base with incurred claims through April 30, 2007, but also reviewed incurred periods closer to the efective date of the proposed rates. Using the updated base claim data from the claim lag triangles provided in response to discovery and the same base period through April resulted in an average increase of 17.4%, down from 18.6% in the original filing. However, looking at a more recent base period through July resulted in an average increase of 13.4% as noted previously in my testimony. Anthem BCBS is proposing to use the twelve month period ending July 31, 2007 as the basis for claims in Exhibit I resulting in a lower proposed average rate increase.

Q. Are there other changes that impact the proposed average increase?

A. Yes. Anthem BCBS has incorporated the Savings Offset Payment announced by the Dirigo Health Agency to be effective July 1, 2008. This change resulted in the SOP percentage proposed in this filing to drop from 1.39% to 1.35%. The calculation of this factor is included in Exhibit VIII.

Also, Anthem BCBS has made a change to the estimated cost associated with the newly mandated hearing aid benefit. An additional factor accounting for the fact that not all those with hearing loss use hearing aids has been included in Exhibit VIII and lowered the estimated cost from $0.34 to $0.21 per contract per month ("PCPM").

Together these two change reduce the proposed average rate increase by 0.1%.

In aggregate the changes described above have reduced the proposed average increase from 18.6% in the original filing to 13.3% included in the amended filing accompanying this testimony.

Q. Have you in any way changed the format of the filing or the methodology for developing the proposed rates?

A. No. The methodology is unchanged so these changes are merely updating data and revising applicable factors where appropriate.

Q. All of the changes that you have proposed serve to lower the required rate increase. What would happen if changes in observed data actually increased the required increase?

A. It seems important to the integrity of the process that a methodology should not be driven by results; rather, a methodology is either reasonable or it is not. If more recent mature claim data would result in a lower required increase, it would be appropriate to approve rates using that more recent data. By the same token, if recent data suggested that rates for the rating period should actually be higher than reflected in the original filing, it would be appropriate to approve rates using that more recent data. If the Bureau's process would not allow approval of rates above those reflected in the notice of hearing for a particular filing, however, adopting a one-sided updating policy would be inequitable and not achieve the desired result of ensuring that rates are not excessive, inadequate or unfairly discriminatory.

Q. You have submitted new trend data in response to discovery questions yet you have not changed the underlying trend assumption. Why not?

A. Just as described above related to the base claim data, the claim data used for analyzing and projecting claim trends requires a period of time to become "mature" due to required estimates of claims incurred but not yet paid. Anthem BCBS has included trend data through June, 2007 in the amended Exhibit VI accompanying this testimony.

Anthem BCBS has not revised its trend projection as it believes that the original projection is still reasonable. The most recent twelve month ending trend is lower than other recent trends, but an analysis of the components of that trend reveal that the primary reason for this lower value is a large drop in inpatient utilization.

While this observed data is informative, it would be historically unprecedented for inpatient utililization to continue to decline as reflected in this recent data. In fact, if inpatient utilization returns to prior levels in recent observed periods, overall trend would increase. As such, it would not be reasonable to assume that observed inpatient trend will hold and therefore is not relied upon in the analysis of trend components.

The projected trend is still reasonable in relation to observed trends and future expectations. The total trend applied to the base claims is 15.1%. The anticipated reduction in claims due to the expected shift in enrollment by benefit option is 6.6%. Coupled together, the underlying assumed trend of 15.1% and the reduction of enrollment shifts results in an annualized claim trend of 9.7%.

It should be noted the the underlying claim trend in the original filing was 15.2% and is now 15.1%. This is the result of a change in the weights by component (inpatient, outpatient, professional, and pharmacy) with new updated claim data and not the result of a change in the trends projected originally.

Q. Compared to last year's filing, have you made any changes in the way you determined the prjected trend in this year's filing?

A. No, the methodology for projecting trend is the same.

Q. What was your projection of trend last year and how does it compare to observed trends?

A. Last year the underlying trend assumption was 18.9% with adjustments for benefit and age band shifts which reduced the actual applied annualized trend to 11.4%. At the time actual observed trends were around 20%. Through July of 2007 the annual trend is 7.6% which is lower than that projected and the lowest trend observed for HealthChoice in recent years.

Q. Given this recent trend of 7.6% is your proposed trend of 9.7% after adjustments for enrollment benefit shifts reasonable?

A. Yes, it is. In last year's filing Anthem BCBS felt it was reasonable to project claims forward at a level far below the extremely high observed level in claim trends witnessed at the time. In this year's filing Anthem BCBS believes it is reasonable to assume a trend that is slightly higher than the extremely low observed level in claim trends. In both cases, both last year and this year, the assumed implied trend is lower than average trends observed over longer periods and also lower than the trend observed after adjustments for the removal of claims over $100,000 for members incurring claims greater than $100,000 in a calendar.

Q. Can you go into more detail describing how the trend is being applied to determine future claim costs?

A. Yes. The trend applied to observed claim costs is 15.1%. This is an annual trend that is applied in the following manner:

> Incurred claims for the 12-month experience period ending July 31, 2007, were estimated as (a) claims paid during the experience period, plus (b) the estimated liability for claims outstanding on July 31, 2007. Liability estimates were based on an analysis of claims paid through September 30, 2007. This particular twelve month period was chosen as it allowed for a substantial amount of "runout" to ensure that the restatement of the estimated outstanding liability would be minimal.
>
> Incurred claims for current benefits were projected using the 15.1% annual trend factor applied to services for the seventeen months between the experience period and the rating period. The resulting HealthChoice projection factor is approximately 1.221 ($1.151^{17/12}$).

As required by previous order of the Superintendent of Insurance, claims are adjusted in order to compensate for anticipated shifts of enrollment among the various benefit options. This adjustment is calculated using observed claim amounts on a PCPM basis coupled with the anticipated subscriber distribution among the benefit options during the rating period. The direct impact of lower claims through anticipated shifts in enrollment will result in an actual benefit paid

trend well below the 15.1% trend applied to claims. Isolating the trend and the adjustments from Exhibit I present a clear picture of the expected claim trend after adjustments. First, the 15.1% trend is applied for seventeen months, as noted above, which results in an adjustment to claims by a factor of 1.221. Second, claims are directly reduced by the estimate of the impact of shifts in benefit plan of 0.934 resulting in an actual claim adjustment of 1.140. Finally, this projection factor is annualized and results in an expected change in benefits paid of 1.097 ($1.140^{12/17}$), or 9.7%.

Q. Could you also give an overview of information that you use in order to determine the trends that are used to determine future claim costs?

A. As described in detail in the Actuarial Memorandum Anthem BCBS has analyzed observed historical claim data patterns for both the cost and utilization of services rendered to HealthChoice members in hospitals, by physicians, and through the purchase of prescription drugs. Along with the analysis of historical patterns, we gather information from Anthem BCBS associates responsible for contracting with providers of healthcare. From this data, we produce an estimate of the expected changes in what Anthem BCBS will pay providers for the services they provide to HealthChoice members. Anthem BCBS then accounts for changes in the mix of services rendered and the impact of deductible leveraging in order to determine a trend which is applied to current claim costs to estimate what claim costs will be during the time when the proposed premiums will be available to pay these claims.

Q. There other components of rates, are any of them changing?

A. No. All other rate components are the same as originally proposed.

- Anthem BCBS projected pharmacy rebate credits at a level of $3.91 PCPM. This is approximately 5% of the expected allowed pharmacy claims for 2008 which is consistent with 2005 and 2006 and an annualized 6% increase over rebates received in 2006. Given the increasing

distribution of generic drugs, which receive no rebates, the rebate credit is reasonable.

- Administrative expenses are projected to remain at the level anticipated for 2007. This assumption may not be achieved, but remains reasonable in light of the slight reduction in administrative expenses year over year from 2006 to 2007.
- The projection of commissions remains unchanged. Commissions are paid on a per contract basis for new sales and the total commission amount paid is spread across the entire HealthChoice enrollment. The new sales projected for the remainder of 2007 and 2008 have not changed so the proposed commission charge is still reasonable.
- The profit and risk charge remains at 3% as originally proposed.

Q. What about the enrollment projections? Have those changed since the original filing.

A. No, they have not. Anthem BCBS projected enrollment through the use of observed patterns applied to future periods. For each benefit option members are projected on a month by month basis through the end of 2008 using an observed trend in enrollment over the past year. The projected contracts are then determined depending on the number of contracts within each benefit option. For those benefit options with less than 1,000 contracts the member per contract ratio for June, 2007 is divided into the number of members for each month in order to determine the number of projected contracts. For benefit options with greater than 1,000 contracts Anthem BCBS divides the projected members by the June, 2007 members per contract ratio which is adjusted by the recent level of change observed in the member per contract ratio. This methodology results in changes of less than 1% in the member per contract ratio for any benefit option. The projected change in the total member per contract ratio is due to the projected change in the distribution across benefit options. Since this distribution is based on recently observed changes Anthem BCBS believes the enrollment projection and the related member per contract ratio are reasonable.

Q. During the discovery process it was determined that some of the proposed rates were out of compliance with the rating requirements included in Rule Chapter 940. How are you responding to this issue?

A. Due to a change in the contract tier rating factor for two adult families from 2.65 to 2.53 the calculated allowable difference between certain benefit options was changed as well. For the benefit options offered as renewal only Anthem BCBS determines the maximum allowable difference in benefits for a family contract to be the amount of difference for one person times the factor used in rating to determine the family rate from the one person rate. This method is used for these benefit options as the family deductible is only met when two members of the family each meet their individual deductible limit.
The change has been made to Exhibit IV resulting in proposed rates now in compliance with the rating requirements of Rule Chapter 940.

Q. You noted previously that new claim data has been utilized in the amended filing. Is this new data included in the amended Exhibits accompanying this filing?

A. Yes. Exhibit V includes the updated claim triangle paid and incurred through September, 2007. Also, Exhibit VI includes detailed claim and associated trend data through June, 2007.

Q. Numerous questions were posed in discovery related to the projection of financial results for the period July through December of 2007. Have you made any changes to this projection based on these questions?

A. Yes, the claim projections for the latter half of 2007 have been modified to reflect the more recent data referenced above. As reflected in Exhibit IX, if the claim projections for the remainder of 2007 hold, Anthem BCBS's pre-tax profit will be 2.6%.

Q. How do you arrive at a required revenue amount after you have accounted for the claim portion of the rate?

A. The required revenue is determined by calculating what will be needed in order to pay projected claims, administrative expenses, premium tax, commissions, profit and risk, and savings offset payment, with an offset for investment income. Following is a summary of how the necessary premiums are calculated:

1. Incurred claims are projected as described previously along with a credit to account for pharmacy rebates earned by HealthChoice prescription drug claims and a credit for a benefit change related to pharmacueticals used for heartburn conditions. Also included is an adjustment for estimated costs due to the proposed expansion of the dependent age to the twenty fifth birthday.
2. Provisions for retention items (administrative expenses, commissions, premium tax, risk and profit, savings offset payment – net of interest income on tax flow) were developed based on projected enrollment, benefits, and administrative costs.
   Administrative expenses included in the filed rates are $37.01 PCPM and are based on a 0% increase applied to the administrative expenses expected in 2007. The result is a decrease of 7.6% from what is included in current rates.
   The commission rate component is based on the increasing payments of $14.75, $15.20, and $15.75 in 2006, 2007, and 2008 respectively. These payments are paid monthly for twenty four months for new subscribers only. The payment amounts, along with projections of new subscribers and the average length of the life of a contract, are combined to determine the amount necessary to fund the commissions to be paid in 2008.
   A projected pre-tax amount of 3% for profit and risk is included in this filing.

Premium tax is included at the statutory level of 2% of premium. An amount has been included as a credit for investment income on cash flow based on the Decision and Order in last year's HealthChoice proceeding.

The SOP is included at 1.35% which is a weighted value based on 1.85% and 1.74% of applicable claims for the first and second half of 2008 respectively. The value applied to determine rates, 1.35%, is lower than the 1.85% and 1.74% due to the fact that the SOP is applicable to claims incurred with in state providers only.

3. Revenue requirements for the rating period are calculated as (a) projected benefit costs, plus (b) the provision for retention items.

Q. Current rates include adjustments approved by the Superintendent for certain benefit plans beyond the allowed rating requirements of Rule 940. Are these adjustments included in the proposed rates included in this filing?

A. Yes, Anthem BCBS used the same adjustments as exceptions to Rule 940 as were approved by the Superintendent in last year's Decision and Order. As it did last year, Anthem BCBS applied these adjustments in order to reflect more appropriately "reasonably anticipated differences in utilization" as the result of differences in benefits. The utilization factors upon which the adjustments are based are small, ranging from 1.0% to 7.6%. They are applied as utilization factors within pricing for the six Non-Mandated options with deductibles $150, $300, $500, $750, $1,000, and $2,250. Both the allowable benefit difference and the utilization factors are used in their entirety. The largest adjustment, 7.6%, is applied to the $2,250 deductible option in relation to the $5,000 deductible option. The other adjustments are applied to the $150, $300, $500, $750 and $1,000 deductible options in relation to the next higher deductible option (e.g. $150 relative to $300 deductible).

Q. Anthem BCBS negotiates reimbursement rates with providers in Maine. Do HealthChoice members receive these discounts when paying claims subject to their member cost sharing?

A. Yes, Anthem BCBS negotiates reimbursement rates with providers for the express purpose of being able to pass on this benefit to its members. Participating providers are contractually required to accept the Anthem BCBS allowed amount when providing services to Anthem BCBS members. Members receive the benefit of these negotiated rates through both lower premiums and lower out of pocket expenses when paying for claims subject to member cost sharing. It is true that some HealthChoice members may not satisfy their annual deductible and thus not receive reimbursed benefits in any given year. However, they do benefit from Anthem BCBS's negotiated discounts for every service they receive and as such they will pay considerably less for those services than if they were paying for them without the benefit of Anthem BCBS's negotiated discounts. As an example, consider a 35 year old one adult subscriber with a $10,000 deductible who receives services from participating providers with an allowed amount of $9,000 and actual charges of $11,250. Anthem BCBS's discounts for these services is 20% off the actual charge. In the absence of this discount the charge to the patient would have been $11,250, but based on the discounts Anthem BCBS was able to secure through provider negotiations, the HealthChoice member saves $2,250. The proposed annual premium in this filing for this subscriber would be $2,367.24. As such, even though the member's deductible is not satisfied, the savings realized in this example are nearly the annual value of the annual premium paid by the subscriber.

HealthChoice members benefit from discounts for all medical service types, including hospital, physician, and pharmacy claims.

Q. What is the loss ratio permitted for these plans and, if the proposed rates are approved, what loss ratios are anticipated for these products?

A. Maine law permits a minimum loss ratio of 65% for products such as HealthChoice. If the proposed rates are approved as filed, and all projections turn out to be accurate, the anticipated loss ratio is 87%, far in excess of the 65% minimum required by law.

Q. Are you filing revised exhibits?

A. Yes. Some of the changes have been described in my previous testimony but there are others, mostly in text within the Actuarial Memorandum, that have been made as well. For ease of reference, Anthem BCBS is providing with this testimony a complete copy of the entire filing, including all Exhibits (as revised), Rule 940 requirements, and the Actuarial Memorandum.

Q. Please summarize the revisions you have made to the exhibits and memorandum and why they were made.

A. The revisions were made as a result of more updated claim data and also information requests in this proceeding. Exhibits changing only as a result of changes made to other exhibits are not noted below. Below is a summary of the revisions to the exhibits.

- Exhibit I
  a. The first row now reads "…Twelve Months Ending July 31, 2007" and the claim base now reflects data through July, 2007
  b. The third row now reads "…annual trend applied for seventeen months" and the claim data is trended for twenty months
  c. The anticipated cost for hearing aids is now estimated to be $0.21 PCPM
  d. The savings offset payment percentage is now 1.35% to reflect the recent issuance of an SOP effective July 1, 2008

- Exhibit II

The calculation of the adjustment for trend is now based on a base period through July, 2007.

- Exhibit III

The calculation of the rate for the $150 deductible with $10,000 annual maximum has been corrected.

- Exhibit IV

a. The contract tier factor for the two adult family contract used in this spreadsheet has been changed from 2.65 to 2.53
b. Rule Chapter 940 allowable rate differences and proposed rate differences have changed for renewable only options
c. The projection of claims for 2007 have been reduced in order to reflect the lower claims observed at the beginning of the second half of 2007. The claim trend now implied in Exhibit IX from 2006 to 2007 is 7.7%. No offsetting change was made to the premium projection for 2007.

- Exhibit V

Claim triangle data is now included through September, 2007

- Exhibit VI

Observed trend analysis data is now included through June, 2007

- Exhibit VIII

a. The savings offset payment percentage is now calculated using both the factor applicable through June 30, 2008 and the factor to be effective July 1, 2008 through the end of the pricing period. The factor to be effective as of July 1, 2008 was not available at the time of the filing
b. An additional factor to account for the percentage of people with hearing loss that use hearing aids is now included in the estimate of the cost of the hearing aid mandate

- Exhibit IX

a. Changes as the result of changes described in pre-filed testimony are reflected in the projected values for 2008.
b. Savings offset payments have been added into the loss ratio calculation for 2006

- Exhibit X

Changes as submitted in response to the Superintendent's first discovery request are included

- Exhibit XI

Changes in labels from "2007" to "2008" as submitted in response to the Superintendent's first discovery request are included

Changes to the Actuarial Memorandum

Language concerning the following topics has been modified in the Actuarial memorandum:

1. The determination of the age band when two adults are on a contract.
2. The effective date of new rates when a subscriber has changed age bands.
3. The DHA's determination of the SOP that will be assessed beginning on July 1, 2008.
4. That there are no proposed changes in contract tier factors.
5. The decrease in proposed rates for the preventive care and supplemental accident rider have been listed for all contract types.

Although these revisions do not affect all exhibits, for the Superintendent's convenience and ease of review and reference, attached to this testimony is a revised copy of the actuarial memorandum and all of the exhibits, in both confidential and non-confidential form.

Q. In your actuarial judgment, are the proposed rates excessive, inadequate or unfairly discriminatory?

A. In my judgment the rates as amended and accompanying this testimony are neither excessive, inadequate, or unfairly discriminatory.

Q. Does this conclude your testimony?

A. Yes

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on October 17, 2007, a copy of the Confidential Version of Prefiled Testimony of William Whitmore was served on each of the persons listed below and in the manner indicated.

Thomas Sturtevant, Esq. (via electronic and U.S. mail)
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DATED October 17, 2007

_____
Christopher T. Roach, Esq.

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